Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Fentanyl
Prior Authorization Form

Incomplete forms will not be reviewed.

Patient's Information:

NAME: _____ DOB: _____

Recipient's Maryland Medicaid Number: _____ SEX: ❑ M ❑ F

Prescriber's Information:

Name of Facility/Clinic: _____

NAME: _____ NPI # _____

Phone # _____ Fax # _____

Contact Person for this Request:

NAME: _____ Phone: _____ Fax: _____

**** Prior authorization is approved for 6 months only****
□ New Prescription □ Refill (Patient has been taking this medication)

Please check the appropriate box for the Fentanyl Prior Authorization request.
□ Quantity Limit □ High Dose □ Non-Preferred □ Other_____

Use a separate form for EACH medication request:
Medication: _____ Strength: _____ Quantity: _____

SIG: _____ Length of Treatment _____ months

Clinical Consideration:

Y	N	
❑	❑	Patient receiving opioid due to cancer treatment. Cancer type:_____
❑	❑	Patient receiving opioid due to sickle cell disease.
❑	❑	The patient is in hospice care.
❑	❑	Patient is Pregnant (where applicable)
Attestation required for each of the following:		
❑	❑	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
❑	❑	Patient has/will have random Urine Drug Screens.
❑	❑	Naloxone prescription was provided or offered to patient/patient's household.
❑	❑	Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in Medical record?

I certify that the benefits of Opioid treatment for this patient outweigh the risks of treatment.

Prescriber's Signature_____ Date_____

Fax completed form to 866-440-9345.